DELAWARE HEALTH AND SOCIAL SERVICES

Division of Developmental Disabilities Services

HIPPA COMPLIANT CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION
Pursuant to 45 CFR 164.508

Individual (DDDS Service Recipient):

Name:		**Birthdate:**
Street Address:		
City:	**State:**	**Zip:**

I, or my authorized representative, herby authorizes the Division of Developmental Disabilities Services (DDDS) to disclose my Personal Health Information and/or any other documents that is requested on this consent form to the designee identified below:

Requesting Individual (to whom the information will be sent):

Name:		**Relationship:**
Street Address:		
City:	**State:**	**Zip:**

Specific information to be released:
☐ Access to my Electronic Case Record
☐ Release of my Person Centered Plan
☐ Release of my Medical Record (specify what records will be released):
☐ Release of information pertaining to an incident or Reportable Incident (specify what records will be released):
_____
☐Other: (Please Explain):
_____

Reason for the release of information:
☐ At the request of the individual
☐Other: _____

Purpose for the information:
_____

My signature indicated that I know exactly what information is being disclosed and have had the change to correct and change the information to make sure it is correct and complete. I am aware that this consent can be revoked in writing at any time.

My signature also means that I have read this form and/or had it read to me and explained in a language I can understand. All blank spaces have been filled in except for signatures and dates.

I have received a copy of this consent for my records.

The consent ends _____ unless revoked by me in writing before that time. This consent is effective immediately and shall stay in effect as stated.

_____ _____ _____
(Individuals signature or "X") (Date signed) (Witness/Date signed)

_____ _____ _____
(Individuals guardian, if applicable) (Date signed) (Witness/Date signed)

_____ _____
(Division Representative) (Date signed)

Authorized Representative, if applicable:

Name:		**Relationship:**
Street Address:		
City:	**State:**	**Zip:**

Please send all consents to: Health Information Management Department
26351 Patriots Way
Georgetown, DE 19947